Orthodontics on Silver Lake, P.A.
Stephanie E. Steckel, D.D.S., M.S.
Welcome To Our Office
*-Please Print –*

ADULT HEALTH HISTORY

Date: _____ 20_____

Date of Birth: _____

Patient's name:_____ Soc. Sec. No:_____
First Middle Last

Name Patient Prefers to be Called:_____ Age:_____ Sex: Male Female

Telephone Number:_____ Other Phone: _____

Home Address:_____Zip Code:_____

Email Address:_____

If lived at address less than five years, previous address: _____

Dentist: _____ Last Check Up: _____

How did you hear about our office: (check all that apply)

□ www.doverorthodontics.com □ Phone Book □ Dentist □ Hygienist □ Dentist Receptionist □ Internet

□ Patient/Relative/Friend: _____ □ Other:_____

Occupation: _____Employed By:_____

Number of Years employed: _____ Business Telephone: _____

Business Address: _____

Marital Status: (circle one) Married Divorced Separated Single

Name of Spouse: _____ DOB: _____Soc. Sec. No.:_____

Occupation: _____Employed By:_____

Number of Years employed: _____ Business Telephone: _____

Business Address: _____

Person responsible for account if other than yourself: _____

Do you have any insurance coverage for orthodontic treatment? Yes No

*Please provide your insurance information for us to help you with submission of claims.

Primary Policy Holder's Name: _____

Primary Policy Holder's Employer:_____

Dental Insurance Company: _____

ID/SS Number: _____ Policy Holder DOB: _____ Group Number: _____

Claims Mailing Address: _____

Claims Telephone Number: _____

## Medical History

Are you in good health? Yes or No
Are you currently under the care of a physician for a specific problem? Yes or No
If Yes, Name of Physician: _____ Reason:_____
List any medication currently being taken. Name of medication/for what condition: _____
Any drug sensitivities: Yes or No If Yes, Name of medication/what reaction_____
Is there a history of serious illness, accident, or operation? Yes or No
If Yes, List/Date:_____
If FEMALE, are you or might you be PREGNANT? Yes No If yes, how many weeks:_____
Do you have LATEX allergies? Yes or No Do you have NICKEL allergies? Yes or No

PLEASE CHECK THE FOLLOWING THAT APPLY

| | | | |
|---|---|---|---|
| ☐ Contact Lenses | ☐ High Blood Pressure | ☐ Asthma or Allergies | ☐ Speech Problems |
| ☐ Glaucoma | ☐ Head or Facial Injury | ☐ Rheumatic Fever | ☐ Emotional Problems |
| ☐ Heart Trouble | ☐ Tonsillitis | ☐ Diabetes | ☐ Endocrine Problems |
| ☐ Kidney Disease | ☐ Hearing Disorder | ☐ Bleeding Problems | ☐ Nervous Disorders |
| ☐ Ear Infection | ☐ Epilepsy | ☐ Adopted | ☐ Hepatitis/Liver Disease |
| ☐ Animal Allergies | ☐ AIDS, HIV+ | ☐ Night Grinding of teeth | ☐ Tuberculosis |
| ☐ Osteoporosis | ☐ Other_____ | | |

## Dental History

Have there been any injuries to the face, mouth, or teeth? _____ ☐ Yes ☐ No ☐ Don't Know
Have you ever had gum disease? _____ ☐ Yes ☐ No ☐ Don't Know
Do you get frequent canker sores, cold sores, or mouth ulcers?_____ ☐ Yes ☐ No ☐ Don't Know
Do you take any forms of fluoride? _____ ☐ Yes ☐ No ☐ Don't Know
Have you been informed of any missing or extra permanent teeth? _____ ☐ Yes ☐ No ☐ Don't Know
Any serious trouble associated with any previous dental treatment? _____ ☐ Yes ☐ No ☐ Don't Know
Have you ever had orthodontic treatment before? If Yes, when/by whom:_____ ☐ Yes ☐ No ☐ Don't Know
Has an orthodontist been consulted previously? If so, by whom?_____ ☐ Yes ☐ No ☐ Don't Know
Has anyone in your family had orthodontic treatment? _____ ☐ Yes ☐ No ☐ Don't Know
Please list any family members treated here _____
Do you have an unusual amount of stress in your life?_____ ☐ Yes ☐ No ☐ Don't Know
Do you or have you ever smoked or chewed tobacco? If Yes, what kind of tobacco/how long? _____ ☐ Yes ☐ No ☐ Don't Know
Reason for seeking orthodontic treatment (what problem do you wish to have corrected?) _____
Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information I should be aware of that we have not discussed. _____

I have read and understand the above questions. I will not hold my orthodontist or any member of her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will inform this practice.

_____ _____
Patient Signature Date

For Office Use Only:
ID Verification

Staff Member Initials: _____

ORTHODONTICS
on Silver Lake, P.A.

# WE WANT TO GET TO KNOW YOU!

**Please tell us about yourself:**

1. Nickname: _____

2. What are your hobbies and interests? _____

_____

3. Do you feel that your teeth are (circle all that apply):

| | | |
|---|---|---|
| Too small or short? | No | Yes |
| Too large or long? | No | Yes |
| Crooked or crowded? | No | Yes |
| Mishaped (uneven/pointed) | No | Yes |
| Off color? | No | Yes |
| Front teeth stick out(buck teeth) | No | Yes |
| Spaces between teeth | No | Yes |

4. How do you feel about having braces or a retainer? _____

_____

5. Do you have friends or family that we treat/treated here? _____

_____

6. Do you have Facebook? □ Yes □ No

**Become a fan of Orthodontics on Silver Lake!**

## WE ARE VERY EXCITED TO HAVE YOU AS A PATIENT AND A NEW FRIEND!

Dr. Stephanie Steckel ● 42 Hiawatha Lane ● Dover, DE 19904 ● 302-672-7776
www.doverorthodontics.com

**Notice of Privacy Practice**
**Revised September 2013**

**Our Legal Duty:** We are required by federal and state law to maintain privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We follow the privacy practices that are described in this Notice. This Notice takes effect (4/14/2003), and will remain in effect until we replace it. We reserve the right to change our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time.

**USES AND DISCLOSURES OF HEALTH INFORMATION**

**Treatment:** We may use or disclose your health information to other healthcare providers providing treatment to you. This office is designed as an open bay treatment area. Discussion of our patient's treatment may occur at times in the open bay.

**Payment:** We may use and disclose your health information to obtain payment for services. This will include insurance information.

**Your authorization for your family and friends:** In addition to our use of your health information for treatment, payment or healthcare operations, we may disclose information to family members, chaperones, or friends that may be involved in your treatment. Please list their name and relationship below.

**Required by law:** If required by law, we may use or disclose your health information without your written authorization. We may disclose your information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or the health or safety of others.

**Telephone/ Mail/ Email/Other Communications:** With this consent, Orthodontics on Silver Lake, P.A. or our business associates may call your home, leave a message on your voicemail, mail correspondences to your home, and/or email any items that assist the practice in carrying out treatment, such as appointment reminders, financial statements, insurance items, and information pertaining to clinical care.

**Marketing:** I consent to the taking of photographs and x-rays before, during, and after treatment, and to the use of the same by the doctor in scientific papers or demonstrations, office promotion and/or social media.

**PATIENTS RIGHTS**

**Patients Right to Access:** You generally have the right to look at and get copies of your health information. We will use the format you request unless we cannot practicable do so. We will charge you a reasonable cost-based fee for expenses such as copies and staffing time. Request for copies within 48 hours will be assessed with surcharge.

**Questions and Complaints:** We support your right to the privacy of your health information. You may file a complaint with us or with U.S. Department of Health and Human Services. If you want more information about our privacy practices or have questions please contact us.

**Notice of Privacy Practice**
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By signing this form, I am consenting to allow Orthodontics on Silver Lake, P.A. to use and disclose my health information to carry out treatment. Other uses of patient information will not be used without patients' written permission. Patients have the right to revoke an authorization as long as the patient does so in writing. This excludes situations in which the office has already relied on the authorization to use or disclose patient information and for purposes of obtaining insurance coverage.

(Print Patient's Name)

(Signature of Patient or Legal Guardian if under 18)

(Print Name of Legal Guardian if under 18)

(Date)

Who may we speak to about the patient's orthodontic treatment? List names and relationship below.

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